CATEGORY: LD.3 LEADERSHIP

Table of Contents

Area: LD.3.1 Executive Oversight

Area: LD.3.2 Business Management

Area: LD.3.3 Human Resource Management

Area LD.3.1 Executive Oversight

Element LD.3.1.1 (formerly LED.2.1.1 and LED.2.1.5)

Executive Management (Senior Leadership)

Evaluation Criteria

- Members of the executive management committee (EMC) were an integral part of the decision process in determining resource requirements, staffing, training, equipping, healthcare optimization and organizational mentoring
- Executive management team set the strategic direction with emphasis on:
  - -- Mission readiness (MTF, wing, MAJCOM, and AFMS)
  - -- Mission support/business plan
    - --- Maximum achievable enrollment reviewed annually and marketing plan developed
    - --- Unit manpower was primarily utilized to optimize delivery of direct patient care
- Executive leaders employed a systematic process to oversee improvement of the unit's performance
- Medical group commander provided direct oversight for:
  - -- Military standards
  - -- Professional development/organizational mentoring
  - -- Duty titles throughout the organization accurately reflected the duties and level of responsibility as required by Objective Medical Group guidance
  - -- Ensured medical support was adequate to meet mission requirements
  - -- Ensured items in EMC minutes requiring further action were tracked/followed to completion

---

Scoring

4: Criteria met.

3: Senior leadership's compliance with AFMS strategy has only minor deficiencies.

2: Although the basic mission was accomplished, senior leadership was not actively engaged in all aspects of the unit's operations or in setting the unit's strategic direction, resulting in decreased mission effectiveness. Ineffective leadership impacted the overall performance of the unit.

1: Senior leadership showed minimal oversight of AFMS strategy. Lack of oversight/involvement by senior leadership contributed to significant HSI findings in medical readiness, unit training, TRICARE or population health.

0: There was little evidence of unit commander leadership/oversight in unit activities. Senior leadership failed to support basic mission requirements.

NA: Not scored.

Protocol	Team Chief Protocol 3 is the pertinent protocol for this element.
Inspector Contact	For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty team chief.
Reference(s)	AFMS FY 02-07 Medical Service Mission Support Plan, Oct 99; Medical Annual Planning and Programming Guidance (MAPPG) FY 04-09; AFI 44-119; AFI 41-120; AFPAM 44-155

Element LD.3.1.2 (formerly LED.2.1.2)

Medical Readiness Staff Function (MRSF)

Evaluation Criteria

- MRSF frequency and attendance complied with AFI 41-106
- Minutes provided a clear, concise summary of discussions and events
- Minutes included status of unit medical readiness training and results of inspections, incident responses and exercises
- Minutes clearly indicated review/approval of following by MRSF:
  - -- Annual training plan
  - -- Annual exercise schedule
  - -- MCRP and base/wing plans that include medical information (annually)
  - -- Unit readiness exercise program including planning, execution and follow-up corrective actions
- The Medical Readiness Decision Support System was used to monitor medical unit preparedness and identify areas for improvement
- Post-exercise or incident summaries were reviewed, and items requiring MRSF involvement were opened and tracked until resolved

---

Scoring

4: Criteria met.

3: Deficiencies in oversight of organizational processes were minor, primarily administrative in nature and did not adversely affect overall program outcome. For example, MRSF minutes did not include some required items or did not reflect some discussions that took place during the meetings.

2: Insufficient or ineffective command involvement caused systemic problems throughout the readiness program that hampered accomplishment of readiness mission requirements. For example:

- An insufficient or missing training plan or exercise schedule caused some inadequate training or missed training requirements
- Plans were overdue review/revision or missing some required coordination
- Some deficiencies identified during exercises were inadequately tracked or closed prematurely
- Deficiencies existed in monitoring of program elements, resulting in lack of oversight or sporadic follow-up of program shortfalls

1: Insufficient or ineffective command involvement caused systemic problems throughout the readiness program that seriously hampered accomplishment of readiness mission requirements. For example:

- An insufficient or missing training plan or exercise schedule caused inadequate training or missed requirements affecting unit readiness

- Several deficiencies noted during exercises were inadequately tracked or closed prematurely
- Plans were significantly outdated or missing most required coordination
- The unit commander and/or other function members routinely missed MRSF meetings, causing a lack of direction or focus for unit readiness

0: Absence of command involvement caused systemic problems throughout the readiness program that seriously hampered accomplishment of readiness mission requirements. For example:
- Poor monitoring of readiness statistics and program elements could adversely impact deployment resources/disaster response readiness
- Most exercise discrepancies were not tracked or resolved
- Plans were outdated with no attempt to make them current through interim updates or formal revision

NA**:** Not scored.

Protocol Administrator Protocol 7 is the pertinent protocol for this element.

Inspector Contact For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty MSC inspector.

Reference(s) AFI 41-106; AFMAN 33-326, Chap 3

Element LD.3.1.3 (NEW)

Professional/Functional Oversight

Evaluation Criteria

- All members of the executive leadership team (ELT) were an integral part of the decision-making process for the MTF
  - -- Functional members of the executive management committee (EMC) addressed specific functional issues that affect mission requirements
  - -- Issues not resolved at the executive management committee were delegated to the appropriate administrative/functional authority for timely resolution
- ELT members provided appropriate oversight for matters that pertained to their areas of responsibility
- The ELT ensured the organization had a mentoring program for all assigned officers, enlisted and civilian personnel and executed their responsibility as mentors for their respective functional areas of expertise

Scoring

4: Criteria met.

3: Discrepancies were minor, primarily administrative in nature, and unlikely to compromise mission effectiveness or professional growth.

2: Functional members of the EMC were not consistently integrated into the decision-making process. Organizational mentoring programs were inconsistently developed or executed. Professional growth and career development could be compromised in some areas.

1: Functional members of the EMC were not involved in decision-making and/or did not provide appropriate oversight for their areas of responsibility. Ineffective mentoring programs hampered the professional growth and development of medical service members.

0: The unit failed to integrate functional members of the EMC into the decision-making process. There was no established mentoring program.

NA**:** Not scored.

Protocol

Team Chief Protocol 3 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty team chief.

Reference(s)

AFI 36-211; AFI 36-2406; AFI 36-3401; AFPD 36-34; HQ USAF/SGMM Objective Medical Group Implementation Guide, Dec 96

Element LD.3.1.4 (NEW)

Executive Oversight of Health Care Delivery

Evaluation Criteria

- A population health workgroup/function/committee was chartered by the executive management committee to provide appropriate guidance for population health activities
- Population health activities were effectively planned, implemented, and overseen; sound epidemiological principles were applied to evaluate population health assessment results by the population health workgroup activities
- There was an established system to ensure data retrieved from assigned population is incorporated into each patient interaction
- The population health workgroup implemented the following seven key processes:
  - -- Identify the population
  - -- Forecast demand
  - -- Manage demand
  - -- Manage capacity
  - -- Evidence-based primary, secondary and tertiary prevention
  - -- Community outreach
  - -- Analyze performance and health status
- Issues that were not resolved by this workgroup/function/committee were elevated to the proper oversight workgroup/function/committee

---

Scoring

4: Criteria met.

3: Minor deficiencies existed that could delay plans to maximize appropriate health care delivery. For example:

- Comprehensive PCM team training had not occurred
- Marketing opportunities were not optimized to resolve the gap between the MAE and enrollment to the MTF

2: There was partial noncompliance that delayed/jeopardized appropriate health care management. For example:

- Unit leadership was not fully engaged throughout the organization in the execution of the unit's strategic healthcare priority/direction
- There was inadequate support staff allocated to PCM teams even though sufficient staff was available in the facility

1: Significant noncompliance with element criteria was evident, seriously impeding the medical health system readiness mission. For example:

- Providers were not functioning in PCM teams. For example, clinics pooled support staff and/or exam rooms or frequent rotation of support staff precluded PCM teams' efficiency

0: There was no PCO implementation.

NA: Not scored.

Protocol

Team Chief Protocol 3 and Nurse Protocol 1 are the pertinent protocols for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty nurse inspector.

Reference(s)

AFMS Population-Based Health (PBH) Plan, Jan 99; HQ USAF/SG Policy to Improve Military Treatment Facility (MTF) Primary Care Manager Enrollment Capacity, Mar 00; HQ USAF/SG memorandum, Population Health Improvement Priority Areas, Apr 00; Department of Defense Population Health Improvement Plan and Guide, Apr 00; A Guidebook to Primary Care Optimization, Jun 00

Element LD.3.1.5 (formerly LED.1.2.1)

Customer Satisfaction/Patient Advocacy Program

Evaluation Criteria

- A mechanism was in place to evaluate patient feedback
  - -- A mechanism existed for prompt and effective resolution of complaints
  - -- Surveys were analyzed and data reported to the executive team
  - -- Identified opportunities for customer satisfaction and improvements were recognized and implemented
- A mechanism existed for basic customer service, satisfaction and sensitivity training
  - -- Unit members were trained on patient advocate requirements
- Unit members were knowledgeable of their roles and responsibilities in promoting an environment of courtesy and sensitivity within the unit and acted accordingly

---

Scoring

4. Criteria met.

3. Deficiencies were minor, primarily administrative in nature.

2. Basic customer service, satisfaction and sensitivity training were inconsistently implemented among staff and patient advocates.

1. Patient advocates and staff had not been trained in basic customer service, satisfaction and sensitivity.

0. Complaint resolution mechanisms were ineffective. Senior leadership had made no progress in implementing the customer service basic initiatives. For example:
   - There was no mechanism for customer service, satisfaction and sensitivity training
   - The patient complaints surveys were not effectively analyzed and consistently reported to the executive team
   - Opportunities for customer satisfaction and improvements were not recognized and implemented

NA: Not scored.

Protocol

Nurse Protocol 2 is the pertinent protocol for this element.

Inspector Contact	For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty nurse inspector.
Reference(s)	HQ USAF/SG memorandum, Implementation of Air Force Medical Service (AFMS) Customer Service Basics, 5 Feb 99; HQ USAF/SG memorandum, Customer Satisfaction, 12 Jun 2000

Element LD.3.1.6 (formerly HCS.1.2.2)

Self-Inspection Program

Evaluation Criteria

- The unit had developed and adhered to a unit instruction which described the entire self-inspection process including:
  - -- A system for tracking and follow-up of open items
  - -- A mechanism to identify open items resulting from self-inspections, HSIs, MAJCOM SAVs, or accreditation surveys by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)
  - -- Guidance and input for the development of checklists from the current HSI Guide, TIG Brief articles, analysis of HSI trends from the AF Inspection Agency website, JCAHO manuals, SAV reports, previous HSI reports and other locally developed items
  - -- A mechanism to ensure each new section chief conducts a formal inspection of his or her duty section within two months of arrival
  - -- A requirement for functional supervisors to review and update local checklists
- The self-inspection program manager consolidated and monitored all discrepancies/open items and periodically briefed their status to the executive committee

Scoring

4: Criteria met.

3: Minor deficiencies existed in the self-inspection program but did not detract from its overall effectiveness.

2: Program deficiencies resulted in inconsistent tracking of discrepancies or minimal oversight of open items.

1: The self-inspection program was minimally functional or recently established. Inconsistent follow-up of a significant number of open items was evident.

0: No viable self-inspection program was established. Organizational discrepancies remained unresolved and placed the unit at significant risk for degraded operations and findings (or repeat findings) through various assessment processes.

NA: Not scored.

Protocol	Administrator Protocol 4 is the pertinent protocol for this element.
Inspector Contact	For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty MSC inspector.
Reference(s)	HQ USAF/SGM memorandum, Self-Inspection Program, 26 Oct 01

Element LD.3.1.7 (formerly LED.1.2.2)

Health Care Council (HCC)

Evaluation Criteria

- The Health Care Council (HCC):
  - -- Was chaired by the medical unit commander
  - -- Was composed of community-wide representation
  - -- Promoted effective bi-directional interaction with key customer groups
  - -- Addressed pertinent issues raised to improve and/or enhance health care services and was directly involved in major policy decisions affecting the facility

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature.

2: The unit did not consistently evaluate customer needs or the unit's effectiveness in meeting those needs.

1: Minimal compliance with evaluation criteria. .

0: Customer requirements, expectations and satisfaction were not assessed.

NA: Not scored.

Protocol

Team Chief Protocol 4 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty team chief.

Reference(s)

AFPD 44-1; AFI 44-102

Area LD.3.2 Business Management

Element LD.3.2.1 (formerly HCS.1.1.1)

Materiel Issue

Evaluation Criteria

- Forward logistics processes were designed to meet customer requirements and/or demands
- Customer materiel issue and training reduced the time clinical personnel spend in logistics functions
- Systematic processes were in place to acquire, receive, issue, account for, transfer, identify excess and dispose of supplies/equipment in a timely manner
- Medical treatment facility commander reviewed and approved/disapproved all AF Forms 601, Equipment Action Request
- Acquisition and accountability actions were routinely monitored and evaluated to improve cost, quality and timeliness of materiel delivery
- Supply and equipment inventories were conducted at least every 12 months
  -- Count lists (including those for war reserve materiel assets) did not contain inventory balance data
  -- Discrepancies were appropriately and correctly resolved (e.g., signed/ approved inventory adjustment vouchers) and records adjusted to reflect actual status
  -- Medical unit commander or administrator reviewed/approved inventory results
- Logistics personnel authorized to purchase through the government purchase card program were appointed in writing and appropriately trained
  -- Monthly reconciliations were routinely and properly conducted
  -- Safeguards prevented abuse and unauthorized use of the government purchase card
- Efforts were made to provide products and services at "lowest delivered cost"
  -- Active participation in regional standardization efforts was evident
  -- Required use/committed volume contracts were used where applicable
- Mandatory modules of the Defense Medical Logistics Standard Support (DMLSS) automated information system were used or written waiver from HQ USAF/SGML was on file

---

Scoring

4: Criteria met.

3: Logistics acquisition programs were adequate. Minor deficiencies did not degrade the ability of clinicians to provide patient care but the timeliness of customer support and coordination was inconsistent.

2: One of the major issue processes was broken or ineffectively managed. Deficiencies affected logistical support to the medical facility. Personnel

were not adequately trained to accomplish logistical support tasks. Inefficient management and out-of-stock conditions resulted. For example, one or more of the following conditions existed:

- There was no consistent application of effective inventory control policies dealing with recurring issues, non-recurring issues, source of supply (Prime Vendor, government purchase card, blanket purchase agreements, etc.), follow-up, receipts, warehouse refusals or item substitutions
- There were limited safeguards to prevent potential fraud, waste or abuse

1: Processes were disorganized and not meeting quality and timeliness requirements. For example, one or more of the following conditions existed:

- Significant deficiencies in logistics support adversely affected the cost, quality, availability and timeliness of materiel
- Identified deficiencies were not followed-up, increasing customers' dissatisfaction

0: There was a pattern of noncompliance with multiple evaluation criteria and/or compliance with basic program requirements was not evident. For example, one or more of the following conditions existed:

- Flight/section leadership did not actively try to remedy identified deficiencies in program management
- There was a high potential for fraudulent use or loss of organizational resources
- Logistical support programs were nonexistent or not relevant to the organization's needs
- Quality and availability of logistical resources were limited or nonexistent
- Ability to respond to patient care needs was adversely affected

NA: Not scored.

Protocol

Administrator Protocol 1 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty MSC inspector.

Reference(s)

AFMAN 23-110, Vol 5; AFI 41-209; HQ USAF/SG memorandum, Mandatory Use of Defense Medical Logistics Standard Support (DMLSS) Automated Information System (AIS), 30 May 00

Element LD.3.2.2 (formerly HCS.1.2.1)

Financial Management

Evaluation Criteria

- Flight commander routinely gave MDG/CC and key management personnel a summary of the MTF's performance and cost effectiveness, population (enrolled and other) served, workload, costs, financial status, staffing, analysis of MEPRS data, and status of resource management programs
- Flight commander conducted cost effectiveness analysis related to primary care optimization
- Flight commander monitored the data collection process and ensured workload, personnel, and financial data was reconciled and validated prior to entry into the Expense Assignment System (EAS)
- Resource management personnel ensured personnel assigned to the MTF were placed against correct position numbers and Organization Structure Code (OSC) on the Unit Personnel Management Roster (UPMR)
- Flight commander or designee met with newly appointed cost center managers (CCM) to discuss local resource management policies and procedures, resource allocation needs, manpower management, workload reporting and MEPRS requirements
- CCM function meetings were held at least quarterly and included updates, budget requirements and ongoing training
  - -- CCMs were provided a quarterly analysis of the MTF's performance, enrolled population, workload, resource consumption and unit cost information
  - -- Flight commander analyzed the MEPRS Detail Unit Cost Report and sent information to the CCMs quarterly
- The locally-produced CCM guide contained, at minimum:
  - -- Information about the Air Force's resource management system, financial management strategies, local resource management policies and procedures, manpower management, workload reporting, the DoD MEPRS, data quality requirements, and data analysis techniques
- CCM function minutes were reviewed by the executive committee and copies provided to all CCMs and resource coordinators

Scoring

4: Criteria met.

3: Minor gaps in compliance existed which may reduce optimal efficiency.

2: Several deficiencies existed that affected the operation of the medical facility. For example:

- The CCM program was disorganized and did little to benefit sections and the medical facility

- RMO staff did not compile or report summaries of the MTF's performance and cost effectiveness metrics for executive staff review

1: Significant deficiencies impaired patient care services or facility operation.

0: Financial mismanagement seriously impaired operations in the medical facility.

NA: Not scored.

Protocol Administrator Protocol 3 is the pertinent protocol for this element.

Inspector Contact For assistance interpreting of this element, please call DSN 246-1771/2566 and request an Active Duty MSC inspector.

Reference(s) AFI 41-120; AFI 65-601, Vol 2

Element LD.3.2.3 (NEW)

Management of Access to Care

Evaluation Criteria

- The MTF Commander designated an access manager, usually the group practice manager (SG PL 28 Mar 01), and a multi-disciplinary team to oversee and integrate the implementation of appointment standardization (APS) and access improvement across all MTF activities (Commander's Guide to Access Success (CGAS) pg II-3; OASD PL 26 Mar 00)
- The access manager/team ensured:
  - -- At least 90 percent of MTF appointments were scheduled using the Managed Care Program (MCP) Module in CHCS; the Patient Appointment and Scheduling Book Appointments Module (PAS BOK) was only used for scheduling dental or self-referral (e.g., optometry) appointments (SG PL 28 Mar 01, Atch 1, para a)
  - -- MTF used one of ten standard appointment types for at least 90% of scheduled appointments (SG PL 28 Mar 01, Atch 1, para c)
  - -- All bookable clinic appointments were viewable by appointing staff at least 30 days in advance, on a rolling basis (TRICARE Access Imperatives (TAI) website – Business Rules; CGAS pg C-5; SG PL 28 Mar 01, Atch 1, para d)
  - -- TRICARE Prime appointments were scheduled within access standards (CGAS pg H-9; TAI website-FAQ):

--- Initial primary care (PCM)	30 days
--- Initial specialty care (SPEC)	30 days
--- Acute (ACUT)	24 hours
--- Routine (ROUT)	7 days
--- Wellness, health promotion (WELL)	30 days
--- Procedure (PROC) with designated duration	provider designated duration
--- Established patient follow-up (EST)	provider designated duration
--- Telephone consult (TCON)	provider designated duration
--- Group care (GRP)	provider designated duration
--- Open Access (OPAC)	Same day patient calls

  - -- Appointing clerks used appropriate notations in MCP indicating why access standards were not met (e.g., patient refused appointment, no appointments available) (CGAS pg C-1; SG PL 28 Mar 01, Atch 1, para e)
  - -- Non-emergent referrals were entered into CHCS using the Consult Order Entry (CON) program (SG PL 28 Mar 01, Atch 1, para f)
  - -- Tracking mechanism existed for referrals, including feedback mechanism to provide the referring provider with the clinical results of the referral (AFI 41-115, para 1.4.12.6 and 1.4.12.8) or notification of subsequent specialty to specialty referral (SG PL 28 Mar 01, Atch 1, para f)
  - -- Beneficiaries called one telephone number for all appointment and referral needs; call routing, if needed, occurred without requiring the patient to make additional telephone calls (CGAS pg C-1; TAI website - Business Rules)
- Appointing processes worked under the assumption of PCM-By-Name

enrollment and followed OASD-HA appointment and referral business rules (CGAS pg C-4; OASD PL 25 May 00; TAI website - Business Rules)

- CHCS detail fields and optional slot comments delineating appropriate limitations of each provider (e.g., patient age or sex, procedures, examinations or medical conditions) were approved at a level consistent with local or regional policy, updated immediately when changes occur and reviewed at least annually (TAI website-Provider templating)
- MTF followed TMA business rules for provider file and table build (TAI website - Provider templating)
- MTF established local policies and procedures to:
  -- Determine the number, type (e.g., ROUT, ACUT, EST, etc), beneficiary recipient (e.g., prime active duty, prime non active duty, non-prime) and duration of appointments needed based on analysis of appointment demand and prior workload history (CGAC pg II-7, pg II-12; TAI website - Business Rules and Access Management)
  -- Adjust schedules to minimize the impact of no-shows, unscheduled provider absences and unbooked same day appointments (TAI website – Clinic templating)
  -- Determine the number of allowable MTF book-only slots per specialty (TAI website - Clinic templating)
- MTF actively monitored progress in improving access
  -- MTF Template Analysis Tool or other appropriate method was reviewed periodically; appropriate adjustments were made to resolve problems (TAI website - Clinic templating)
  -- MTF projected daily, weekly, monthly appointment demand in coordination with department chiefs and staff availability; deltas were resolved and managed before a crisis occurs (TAI website - Access Mgt); feedback was provided to clinics (CGAS, pg II 14)
  -- CHCS Access to Care reports were reviewed, trended and acted upon as needed (CGAS, pg F-2; SG PL 28 Mar 01, Atch 1, para b)
  -- Senior leadership was briefed on the status of access management and correction actions (TAI website - Access Mgt)
- Prior to implementing open access (OA), the MTF developed a business plan that was compliant with TMA implementation guidance and addressed at a minimum:
  -- Staffing
  -- Integration of involved components of healthcare delivery (e.g., lab, pharmacy, immunizations, etc.)
  -- Outcome measures for access, quality, and patient/staff satisfaction
  -- Business plan was approved by the MTF's MAJCOM prior to implementation (SG PL 18 Jun 02, Improving Access to Care Using the Open Access Model)

Scoring

4: Criteria met.

3: Minor deficiencies did not degrade the ability of clinicians to provide the right patient care at the right time but the availability of appointments and timeliness of corrective action was inconsistent.

2: One of the major processes for access management was broken or ineffectively managed. Deficiencies affected appointment availability to the community. Personnel were not adequately trained or qualified to manage access. For example, one of the following conditions existed:

- There was no designated MTF individual that actively managed access for the community
- Template Analysis Tool indicated inappropriate balance of available appointment type and beneficiaries type to meet patient demand. Access management was not monitored at appropriate levels of management within the MTF
- Provider and clinic templates were minimally effective in meeting demand and did not reflect current provider/appointment limitations

1: Multiple processes for access management were broken or ineffectively managed, significantly impacting appointment availability. For example, several of the following conditions existed:

- There was no designated MTF individual that actively managed access for the community
- Template Analysis Tool indicated inappropriate balance of available appointment type and beneficiaries type to meet patient demand. Frozen and blocked appointments were evident without sufficient explanation or resolution
- Access management was not monitored by senior leadership
- Provider and clinic templates were not established in accordance with OASD-HA business rules
- Identified deficiencies were not followed-up, increasing customers' dissatisfaction

0: There was a pattern of noncompliance with multiple evaluation criteria and/or compliance with basic program requirements was not evident.

NA: Not scored.

Protocol

Administrator Protocol 6 is the pertinent protocol for this element.

Inspector Contact	For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty MSC inspector.
Reference(s)	ASD(HA) memorandum, Policy for Standardized Appointment Types, 25 May 00; ASD(HA) memorandum, Appointment Standardization Program (APS) Guidance, 26 May 01; HQ USAF/SG memorandum, Improving Appointment and Access Business Practices, 28 May 01; Commander's Guide to Access Success, 15 May 02; AFI 41-115; TRICARE Access Imperatives Website; HQ USAF/SG memorandum, Improving Access to Care Using the Open Access Model, 18 Jun 02

Element LD.3.2.4 (formerly HCS.1.1.3)

Management of Controlled Medical Items

Evaluation Criteria

Processes ensured compliance with regulatory requirements concerning the acquisition, receipt, storage, issue, distribution, inventory, and/or disposition/destruction of controlled medical items. These processes included, but were not limited to:

- Controlled access by authorized personnel, with an E-5 or GS-5 or above appointed as controlled medical item custodian
- Current Drug Enforcement Agency (DEA) registration
- Reporting loss or theft of controlled substances to the regional DEA activity
- Documented chain of custody for all controlled items as evidenced by authorized signatures on Issue/Turn In Listings
- Monthly and biennial inventories (to include war reserve materiel controlled items) were conducted by a disinterested officer in the grade of MSgt/GS-7 or above
- Biennial inventories were recorded on the 30 April Monthly Controlled Item Transaction Register (odd years) and an inventory certificate accomplished
- Destruction was accomplished or contracted according to AFMAN 23-110 Vol 5 and a MEDLOG destruction document or DD Form 1348-6 was completed to include identity and quantity of items destroyed and the authority, reason, manner, date of destruction and signatures of two destruction witnesses of grades not less than that of the destruction officer

Scoring

4: Criteria met.

3: Minor deficiencies existed which did not compromise the integrity of controlled items management processes.

2: There was partial compliance with one or more evaluation criteria; however, there was potential for misuse and/or abuse of controlled medical items.

1: There was limited compliance with one or more evaluation criteria. The potential for misuse and/or abuse of controlled medical items put the organization at significant risk of losing DEA approval to acquire narcotics.

0: There was noncompliance with multiple evaluation criteria and/or compliance with basic program requirements was not evident. For example, one or more of the following conditions existed:

- The organization was not in compliance with federal requirements

- Processes were not effective and negatively impacted healthcare delivery
- Lack of management oversight and follow-up actions seriously jeopardized DEA certification

NA: Not scored.

Protocol

There is no protocol for this element. Interview will take place in the controlled item storage area(s) with the vault custodian and other personnel at unit discretion.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty MSC inspector.

Reference(s)

AFMAN 23-110, Vol 5

Element LD.3.2.5 (formerly HCS.1.2.5)

Data Quality

Evaluation Criteria

- The MTF commander appointed a Data Quality Manager (DQM), who has responsibility to accomplish data quality management activities
- A cross-functional data quality team chaired by the DQM included, at minimum, clinical, information systems, patient administration, EAS/MEPRS, budgeting/accounting, health records, coding auditors, and other functional experts as needed
  - -- The team provided regularly scheduled presentations of data quality indicators to executive management teams
  - -- Verifications/audits were performed on inpatient, outpatient, and expense workload reporting systems
- There was a registered health information administrator (RHIA), registered health information technician (RHIT), or a certified coding specialist to oversee and ensure the quality of the coding and the documentation to support the codes
- The MTF had an easily auditable workload collection and reporting system, and workload was verified/audited at the following levels:
  - -- All visits accounted for in CHCS had adequate documentation in the appropriate patient's outpatient record or other acceptable form
  - -- All "kept" appointments were accounted for using ADM
  - -- Documentation in the outpatient record supported the ICD/CPT/HCPCS codes appearing in ADM
- The MTF audit sample should represent a statistically significant number, and will be at least one days' patient visits per month from each separately organized specialty or ancillary service for which visits are reported
  - -- Verification/audits will be conducted monthly unless a clinic has no errors in three consecutive months, then verification/audit may be reduced to quarterly
  - -- Clinics with error rates exceeding 10 percent per month for three consecutive months had data verified weekly until the error rate had been reduced to less than 10 percent for at least two consecutive weeks
  - -- Verifications/audits were documented to include date performed, number of records reviewed, and findings

Scoring

4: Criteria met.

3: Minor program deficiencies existed but program integrity was not compromised.

2: Program deficiencies resulted in inconsistent tracking of data quality or inadequate oversight of discrepant functional areas.

1: Management controls were not functional or were recently established. Commanders and/or managers had not provided necessary oversight to ensure reporting activities complied with procedures, policies, and requirements.

0: There was no viable management control program and there was a significant potential for reporting erroneous workload and financial data.

NA: Not scored.

Protocol Administrator Protocol 5 is the pertinent protocol for this element.

Inspector Contact For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty MSC inspector.

Reference(s) AFI 41-120; AFI 41-210 (Chap 6 and Atch 13); AFPD 65-2; AFI 65-201; Data Quality Improvement Guide

Element LD.3.2.6 (formerly HCS.1.2.3)

Medical Services Account/Third-Party Liability/Third-Party Collections

Evaluation Criteria

- A MSA was established and operated IAW DoD 6010.15-M
- A TPC marketing program existed for patients and MTF staff which included posters throughout the MTF, semiannual letters to retirees, pamphlets available at all possible patient stops, and briefings at commander's calls and retiree forums
- A TPC incentive program included distribution of a percentage of funds collected to active participants as an incentive for MTF personnel to support the program
- MTF staff at all patient entry points were familiar with procedures for obtaining and documenting other health insurance (OHI) information
- Business office personnel/TPC contractor:
  - -- Conducted monthly random reviews of a representative sampling of non-active duty patient medical records to ensure health insurance had been accurately identified
  - -- Reviewed a representative sample of medical records monthly and reconciled insurance information between CHCS/TPOCS and the medical record
  - -- Conducted recurring training on at least a quarterly basis to all personnel responsible for interviewing patients for OHI
  - -- Conducted weekly reviews of representative samplings of billings to identify other potential billable encounters either associated with or resulting from previous episodes of care
  - -- Followed up claims at a minimum of every 30 days and maintained an audit trail showing all attempts to collect from payers
  - -- Set goals to reduce accounts receivable to 60 days or less
  - -- Billed OHI on behalf of the other uniformed services and then balance billed the uniformed service up to the interagency rate on the DD7/7A
- There was a memorandum of understanding (MOU) established with the base's staff judge advocate (SJA) outlining MTF and SJA responsibilities for delinquent TPCP claims
  - -- Ensured only an official of the U.S. government, not contractor personnel, closed delinquent accounts due to invalid reduction or denial
- There was an active, documented audit and compliance program
- There was an MOU with the SJA covering the notification procedures, preparation and follow-up for AF Forms 438
- Internal procedures were developed outlining clinical service coordination, tracking of civilian medical care paid for by the government, and establishing appropriate procedures for closing cases
- A CHCS report was developed which identified hospital admissions and visits related to injuries, and the report was compared to AF Forms 1488

- Medical records were appropriately identified for TPL/MAC cases
- A quarterly reconciliation of submitted claims was accomplished with SJA, discrepancies corrected, and a report forwarded to the SJA and MDG/CC

Scoring

4: Criteria met.

3: Minor program gaps may reduce collections. For example, a marketing program existed but did not reach most intended recipients.

2: Deficiencies may have reduced collections and impacted organizational budget decisions. For example, one or more of the following existed:
- No TPC training had been provided to personnel responsible for interviewing patients for OHI nor were patients asked about OHI
- TPC claims were not followed up every 30 days and/or audit trails were not maintained showing attempts to collect from payers
- Internal audit procedures, including random reviews of patient medical records and billings, were not used to maximize TPC collections

1: Significant deficiencies impacted collections and were detrimental to budget allocation. For example, no TPC marketing program had been developed for patients and staff and there was significant negative impact on collections as a result.

0: Nonexistent or extensive deficiencies made the program(s) ineffective, resulted in minimal collections, and negatively impacted budget planning, execution and mission accomplishment.

NA: Not scored.

Protocol

Administrator Protocol 3 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty MSC inspector.

Reference(s)

AFI 41-120; AFI 51-502; DoD 6010.15-M

Element LD.3.2.7 (formerly HCS.1.1.2)

Professional Services Contracts/Blanket Purchase Agreement (BPA) Oversight

Evaluation Criteria

- Quality assurance evaluators (QAE), if required, were appointed and trained
- Quality assurance surveillance plans (QASP) for professional medical non-personal service contracts over $100,000 were developed and monitored
- Contract documentation was maintained as required
  - -- Documentation existed indicating coordination with, and oversight by, the unit's credentials program manager
  - -- Examples include copy of the contract and all modifications, receiving reports and, if applicable, QAE appointment letter(s) and training
- BPAs, which do not require QASPs, had current, approved price lists, (if pre-priced), and receiving reports prior to payment being made
- Processes were in place to address issues or incidents involving contract healthcare providers

Scoring

4: Criteria met.

3: Minor program deficiencies existed which did not affect contract performance or quality of care provided.

2: Inefficient processes hindered administrative oversight of professional service contracts and/or BPAs.

1: Processes to oversee contracts and evaluate adequacy of contractor performance were deficient. The likelihood of accepting nonconforming contract services was high.

0: There was noncompliance with multiple evaluation criteria and/or compliance with basic program requirements was not evident. Contract requirements were not met and/or inadequate/inappropriate provider performance was not addressed.

NA: Not scored.

Protocol

Administrator Protocol 2 is the pertinent protocols for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty MSC inspector.

Reference(s) DoDI 1402.5; AFI 41-209; AFI 44-119; AFI 44-102; AFI 63-124; HQ AFMSA/SGSLC memorandum, Professional Services Checklist, Aug 98

Element LD.3.2.8 (formerly HCS.1.3.1 and LED.2.1.6)

TRICARE Management

Evaluation Criteria

- The MTF provided member services to DoD beneficiaries, which included health benefit counseling, TRICARE enrollment, marketing and education, assistance with claims, an information desk, patient advocacy and clinic liaison
- The MTF established provider services to support both in-house and external providers and the associated appointments/referrals
- The MTF submitted resource sharing/resource support (RS/S) proposals to their respective MAJCOMs for coordination/approval during the proposal phase, prior to signing a RS/RSA with a contractor
  -- Proposal included the contractor's cost analysis and the projected cost impact with and without resource sharing
- MTF established a contract officer technical representative who conducted activities IAW lead agent requirements
- A debt collection assistance officer (DCAO) was appointed for the MTF
  -- Marketing material/public announcements notified the community about who the DCAO was and their function
  -- The DCAO properly filed and followed up on collection/credit cases in a timely manner
- The MTF commander had designated a primary and alternate beneficiary counseling and assistance coordinator (BCAC)
  -- MTFs had advertised the BCAC position within the community and established a mechanism for 24/7 coverage, e.g., answering machine after normal duty hours with guidance for emergency versus routine requests, directing caller to appropriate resource
  -- The BCAC provided comprehensive briefings to beneficiaries
  -- The BCAC maintained a formal documentation process for tracking actions and problem resolution
- TRICARE enrollment and education was included in base in-processing and out-processing programs
- The medical unit had established policies to support enrollee requests to switch PCMs during an enrollment period
- The MTF commander appointed a Health Insurance Portability and Accountability Act (HIPAA) POC and interdisciplinary team that included at least one clinical, one patient administration, and one information technology representative
  -- The interdisciplinary team attended HIPAA awareness training

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature and did not compromise access to care.

2: There was partial compliance with one or more evaluation criteria. For example:

- Beneficiaries were deprived of essential TRICARE information
- A BCAC and/or DCAO had not been appointed and information about these positions had not been publicized adequately
- MTFs did not submit RS/S proposals to their respective MAJCOMs
- The DCAO was not properly filing and/or following-up on collection/credit cases in a timely manner
- The MTF commander had not appointed a HIPAA POC and interdisciplinary team

1: There was minimal compliance with one or more evaluation criteria considerably hindering access to care and increasing the risk for adverse health outcomes. For example:

- There was widespread unfamiliarity with the TRICARE program at both the medical unit and beneficiary level
- The system in place was minimally responsive to patient needs, e.g., 24/7 BCAC coverage did not exist and emergency request guidance was unavailable after normal duty hours to direct callers to appropriate resources

0: There was no compliance with evaluation criteria, causing considerable concern among beneficiaries and a potential reduction in enrollments.

NA: Not scored.

Protocol Administrator Protocol 6 is the pertinent protocol for this element.

Inspector Contact For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty MSC inspector.

Reference(s) AFI 41-210; AFI 41-115

Area LD.3.3 Human Resource Management

Element LD.3.3.1 (formerly LED.2.1.4)

Squadron Leadership

Evaluation Criteria

- Squadron commanders:
  - -- Worked with the medical group commander and executive leadership to optimize the medical service mission
  - -- Interacted with other medical squadrons and flights as needed to improve organizational performance, including collaboration to manage personnel and other resources
  - -- Ensured squadron management teams include leadership from the various disciplines in the squadrons
- Ensured dissemination/communication of NOTAMS and sentinel events
- The organization had a mentoring program for all assigned officers, enlisted and civilian personnel
- Immediate supervisors were aware of and executed their responsibilities as primary mentors for their subordinates
- There was a written plan used by squadron and flight commanders for periodic counseling. Counseling included:
  - -- Assessment and discussion of performance, promotion potential and professional development plans
  - -- Development of professional/career related skills
  - -- Importance of completing appropriate Professional Military Education
  - -- Importance of earning advanced academic degrees
  - -- Exploration of specialty career path milestones
- Military and professional career enhancement resources were available for reference and used by all personnel
- Medical unit personnel demonstrated compliance with military standards, such as courtesy, dress, bearing, behavior, weight and fitness

---

Scoring

4: Criteria met.

3: Insufficient squadron or flight leadership resulted in suboptimal performance but no significant mission impact at present.

2: Squadron and/or flight leadership was not fully engaged in providing direction and supervision to optimize mission support.

1: Negative mission impact resulted from:

- Inadequate squadron and/or flight leadership
- Sporadic cooperation between squadrons and/or flights
- Inefficient resource allocation

0: Squadrons and/or flights failed to cooperate in support of medical unit mission. Leaders did not communicate effectively with senior leadership or each other, seriously impacting their effectiveness.

NA: Not scored.

Protocol

Team Chief Protocol 3, Team Chief Protocol 8, Senior Enlisted Protocol 7 and Senior Enlisted Protocol 8 are the pertinent protocols for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty team chief.

Reference(s)

AFI 36-2611; AFI 36-2406; AFI 36-2903; AFI 36-3401; AFPD 36-3401; AFPD 40-5; AFPAM 36-2241,Vol 2, Chap 7; AFI 40-501

Element LD.3.3.2 (formerly HCS.2.2.2)

Supervisory Involvement – On-the-Job Training (OJT)

Evaluation Criteria

Unit supervisors:

- Developed a work center master training plan (MTP) to ensure 100 percent task coverage. As a minimum, the plans included:
  - -- Master Task Listings
  - -- Current Career Field Education and Training Plans (CFETP) or Air Force Job Qualification Standards (AFJQS)
  - -- Locally developed AF Form 797, Job Qualification Standard Continuation Sheet (if applicable)
- Managed, evaluated and conducted OJT:
  - -- Maintained 6-part training folders for assigned personnel
    - --- Records reflected accurate and current qualifications and training requirements
    - --- Documented training, as appropriate, according to instructions provided in the respective CFETP
  - -- Conducted and documented orientation of the trainee to the work center within 60 days of assignment
  - -- Briefed and familiarized the trainee with the concepts, scope, objectives, requirements, and procedures of the unit OJT program
  - -- Conducted and documented (on AF Form 623a) initial evaluation of knowledge and skills within 60 days of assignment (utilizing the CFETP, work center MTP and contingency and wartime training)
  - -- Ensured certifiers evaluated and validated core and critical tasks
- Initiated action to award skill level when trainee met all upgrade requirements defined in the respective CFETP
  - -- Verified the individual's training folder had documented evidence to support upgrade actions
- Administered the work center Career Development Course (CDC) program:
  - -- Adhered to 30 day completion schedule, per volume for CDCs
  - -- Unit review exercises:
    - --- Scored the ECI Form 34, Field Scoring Sheet
    - --- Conducted review training with trainee on missed areas
    - --- Certified trainee had completed review training by completing the bottom of the ECI Form 34
    - --- Maintained ECI Form 34 in training folder until course completion
  - -- Conducted and documented a comprehensive review of the entire CDC with trainee in preparation for course examination
  - -- Conducted appropriate follow up to course examination failures
- Attended unit education and training meetings

Scoring

Note: Element rating is determined using a combination review of appropriate documentation of the 6-part training folders and program management (duties and responsibilities of the supervisor as defined in CFETPs and AFI 36-2201).

4: Criteria met.

3: Deficiencies were minor and unlikely to compromise individual training progress or unit readiness. For example:
- Missing or misfiled documents in the 6-part training folder
- Supervisors did not routinely attend OJT meetings

2: Partial compliance with evaluation criteria. Deficiencies could cause possible compromise of trainees' job proficiency, skill-level advancement, or unit readiness. Thirty percent or more of reviewed 6-part training folders contained documentation errors. For example:
- Core tasks were not consistently identified or certified
- Inconsistent/inappropriate documentation on AF Form 623a, Continuation Sheet
- AF Form 2096 (or equivalent) was not accurate or current, or program management deficiencies existed. For example:
  - Initial evaluation of knowledge and skills not consistently accomplished
  - CDC program was not effectively managed

1: Minimal compliance with evaluation criteria. Significant deficiencies existed which would cause probable compromise of trainees' job proficiency, skill-level advancement, or unit readiness. Forty percent or more of reviewed 6-part training folders contained significant documentation errors, or significant program management deficiencies existed. For example:
- Functional work centers did not have an accurate/current MTP
- 6-part training folders contained outdated CFETPs
- CDC program was inefficient or ineffectively managed
- Individuals had received skill-level upgrades without all CFETP defined training requirements accomplished

0: Noncompliance with evaluation criteria. Fifty percent or more of reviewed 6-part training folders contained significant documentation errors. Program deficiencies directly limited unit readiness and adversely impacted skill-level advancement of assigned personnel.

NA: Not scored.

Protocol	Senior Enlisted Protocol 3 is the pertinent protocol for this element.
Inspector Contact	For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty senior enlisted medical inspector.
Reference(s)	AFI 36-2201; CFETP (AFSC specific)

Element LD.3.3.3 (formerly HCS.2.3.2 and HCS.2.3.3)

Life Support Training

Evaluation Criteria

- All personnel received Basic Life Support (BLS) training as required
- Personnel were trained/certified in Advanced Cardiac Life Support (ACLS), as required
  - -- Waiver letters signed by the unit commander were placed in credentials files for providers having sufficient experience in managing cardiopulmonary arrest
- Personnel involved in using the automatic external defibrillator (AED) were trained based on the AED chapter in the ACLS manual
- Personnel were trained/certified in Pediatric Advanced Life Support as required
- Emergency medical technician certification was maintained and those not in compliance were identified and appropriate actions taken
- There was an effective management system in place for scheduling, tracking and reporting individual and organization-wide currency in life support

Scoring

4: Life support training currency maintained at 90-100 percent for at least 12 months prior to inspection.

3: Life support training currency maintained at 90-100 percent for at least six months prior to inspection.

2: Currency maintained at 80-89 percent for at least six months. Ineffective management or insufficient resources were available to achieve training requirements. There was potential for compromise of patient care during emergencies.

1: Currency maintained at less than 80 percent for at least six months. There was a high risk of compromise of patient care during emergencies.

0: Training program was ineffective and/or maintained in such a manner that assessment of the unit's life support training rate is not feasible. Compromise of patient care during an emergency could be reasonably anticipated.

NA: Not scored.

Protocol	Senior Enlisted Protocol 4 is the pertinent protocol for this element.
Inspector Contact	For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty senior enlisted medical inspector.
Reference(s)	AFI 44-102; 1994 American Heart Association Advanced Cardiac Life Support, Chap 4 (for AED)

Element LD.3.3.4 (formerly HCS.2.2.1)

Administration of the On-the-Job Training (OJT) Program

Evaluation Criteria

The unit training manager (UTM):

- Instructed and administered the Air Force Training Course for the unit
  - -- Obtained assistance from the base training office if UTM is not a 3S2X1 or qualified instructor
- Interviewed newly assigned personnel within 30 days to determine training status and CDC progression
- Conducted comprehensive orientation for trainees initially entering upgrade training within 60 days of assignment, covering the concept, scope and objectives of the Air Force training
- Conducted unit training meetings at least quarterly
  - -- Prepared meeting agenda/minutes, distributed to work centers, unit commanders and base training
  - -- Discussed training trends, policies, methods, procedures, and changes
  - -- Reviewed training problems and solutions
  - -- Attended base training meetings
- Provided current copies of CFETPs, AFJQSs, and STSs for each enlisted specialty in the unit (as required)
  - -- Briefed the unit commander monthly on the status of the unit's OJT program, as described in AFI 36-2201 V3, AF Training Program OJT Administration
- Conducted informal work center visits and maintained memos for record until the unit staff assistance visit (SAV) was complete
- Conducted an assessment of the unit training programs NLT 180 days after the base SAV, not to exceed 24 months between unit SAVs. Submitted a written report within 30 days of completion to the unit commander and base training office
- Ensured work centers:
  - -- Developed a master training plan
  - -- Met enlisted duty and skill requirements utilizing MTP
  - -- Conducted initial evaluation of knowledge and skills within 60 days of assignment
  - -- Planned and scheduled training
  - -- Managed testing
  - -- Evaluated qualifications before certification of upgrade actions
  - -- Documented training in six-part folder
- Ensured commander had designated, in writing, qualified trainers/certifiers
- Generated the training management report roster monthly and briefed the commander on the status of each trainee. Ensured the commander signed the OJT roster
- Coordinated training status code changes, skill level upgrades, and AF Form 2096 with supervisors, commander, and base training manager

- Managed the career development course (CDC) program for the unit
  -- Briefed supervisor and trainee on responsibilities
  -- Monitored progress to ensure courses were completed within time limits
  -- Ensured a process was established to track volume completion
  -- Ordered CDCs, course examinations, and scheduled testing
  -- Ensured appropriate follow up was conducted for course exam failures

---

Scoring

4: Criteria met.

3: Deficiencies were minor, primarily administrative in nature, and unlikely to compromise unit readiness. For example:
- Trainer/certifier designation letter had not been updated
- Formal assessment of unit training program had not been forwarded to the base training manager within 30 days
- UETM did not always attend base training meetings

2: Partial compliance with evaluation criteria. Deficiencies existed in program management, which could compromise OJT program effectiveness and unit readiness.

1: Minimal compliance with evaluation criteria. Significant deficiencies existed, which could compromise program effectiveness and unit readiness.

0: Unit training program failed to meet minimum provisions of the evaluation criteria. Program deficiencies directly limited unit readiness and adversely impacted skill level advancement of assigned personnel.

NA: Not scored.

Protocol

Senior Enlisted Protocol 3 is the pertinent protocol for this element.

Inspector Contact

For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty senior enlisted medical inspector.

Reference(s)

AFI 36-2201; CFETP (AFSC specific)

Element LD.3.3.5 (formerly HCS.2.1.4)

Abeyance, Inquiry/Investigation and Adverse Actions

Evaluation Criteria

- Abeyance was timely and properly used to evaluate providers whose professional conduct, practice or health warranted review with temporary removal from patient care, but not summary suspension
- Processes existed to gather information for the objective evaluation of providers whose professional conduct, practice and/or health were suspect
  -- Documentation provided an audit trail and confirmed due process was followed when inquiries or investigations were conducted
- Adverse actions included suspension, restriction, limitation or revocation of privileges
  -- Actions were appropriately applied
  -- Duration was within guidelines
  -- Appropriate coordination done (Staff Judge Advocate, MAJCOM/SG, etc.) and notification to higher headquarters made per directives
  -- Documentation was present as required per directives
  -- Off-duty employment was suspended if applicable

Scoring

4: Criteria met.

3: Minor lapses in timeliness, documentation or processes occurred.

2: Delays or significant documentation lapses occurred, but not to the extent that due process was compromised.

1: Abeyance, inquiry/investigation or adverse actions performed improperly, poorly documented, substantially delayed or subsequent actions taken were faulty to the extent that due process was potentially compromised or potential existed for a negative patient care outcome.

0: Abeyance, inquiry/investigation or adverse actions were not used when appropriate, not documented or so untimely as to violate due process, expose patients to known risk or create high potential for medicolegal actions.

NA: Not scored.

Protocol	Team Chief Protocol 7 is the pertinent protocol for this element.
Inspector Contact	For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty team chief or physician inspector.
Reference(s)	AFI 44-119

Element LD.3.3.6 (formerly LED.1.2.3)

Training Affiliation Agreements (TAA)

Evaluation Criteria

- Memoranda of Understanding (MOU)/Training Affiliation Agreements (TAA) between medical organizations were prepared and processed IAW AFI 41-108
  - -- The MOU/TAA was current and clearly outlined medical organization responsibilities
    - --- The MOU/TAA was dated and signed by the organization commanders or equivalent
    - --- The appropriate approval process was followed IAW governing directive (SJA, group/wing, Air Staff)
    - --- A description of the facilities entering into the agreement was included along with complete addresses
    - --- Liability requirements and responsibilities of the affiliating civilian institution were addressed
    - --- Roles and scope of practice were defined for each participant
    - --- MOUs/TAAs were reviewed for appropriateness and currency periodically (not less than every 3 yrs)
- An effective system of communication existed between the medical organizations
- Supplier/receiver effectiveness was systematically evaluated and feedback was evident
- MOUs/TAAs with non-AF, DoD facilities stated facility responsibilities

Scoring

4: Criteria met.

3: There was significant compliance with criteria; however, some MOUs or TAAs were greater than 3 years old and/or in need of revision, or supplier effectiveness was not always evaluated.

2: Occasional communication lapses between the medical facility and the civilian or federal institution led to inefficiencies in training and/or medical operations. Effectiveness was not routinely monitored, allowing inadequate or ineffective mission support to persist. MOUs or TAAs did not exist for all involved agencies or were not reviewed as required.

1: Communications were clearly inadequate. There was a possibility of adverse impact on mission accomplishment.

0: Severe communication problems impacted mission accomplishment. MOUs or TAAs did not exist. Supplier performance was not monitored.

NA**:** Not scored.

Protocol	There is no protocol for this element. This element is evaluated via document review and a brief interview with the unit's TAA monitor.
Inspector Contact	For assistance interpreting this element, please call DSN 246-1771/2566 and request an Active Duty nurse inspector.
Reference(s)	AFI 41-108; AFI 25-201